

OUTCOME

Page 1 of 1

Agency Name: _____
 Provider-Assessor # _____
 Assessment Date: _____

Applicant Name: _____
 Social Security # _____
 MaineCare # _____

SECTION T. ASSESSMENT TYPE/VERSION			
1.	TYPE	1. Initial (original) 2. Reassessment	
2.	VERSION	1. Original 3. Conversion 5. Reinstated 2. Revision 4. Pending appeal 6. Update	
3.	ASSESSMENT/COMMUNITY PROGRAM ELIGIBILITY	1. Assessment Requested from 6B — <i>Check only one.</i> 2. Community Program Eligibility from scoring pages — <i>Check all that apply.</i>	
1. ASMT REQUESTED	2. PROGRAM	1. ASMT REQUESTED	2. PROGRAM ELIGIBILITY
	1. Long Term Care Advisory		16. 20-day copay to NF MaineCare
	2. Adult Day Care Program		17. 30-day Community MaineCare NF
	3. BEAS Home Maker		18. Advisory to MaineCare Update
	4. MaineCare Day Health		19. Adv. Medicare to Private Pay NF
	5. Consumer Directed PCA		20. Continuing Stay Review
	6. Home Based Care		21. Extraordinary Circumstances to NF
	7. Phys. Dis. HCB		22. Katie Beckett
	8. Elderly HCB		23. Level IV - NF PDN
	9. Adult w/ Disability HCB		24. Congregate Housing
	10. PDN - Level I, II, III		25. TBI
	11. Adult Family Care Home		26. MaineCare Home Health
	12. Level V - Extended PDN		27. PDN Medication - Level VI
	13. NF Assessment		28. PDN Venipuncture Only - Level VII
	14. 20-day Medicare/MaineCare		29. Cons. Directed HCB
	15. Medicare to MaineCare		
4.	CONSUMER CHOICE (Choose one.)	1. Community Options 3. Advisory only 5. NF 2. Residential Care 4. No choice	
5.	ADVISORY PLAN	Program referrals given to consumer as an advisory 0 - No 1 - Yes Advisory medical eligibility determination is valid for 30 days. Valid from: _____ to _____ 0 - NA	
SECTION U. NF MEDICAL ELIGIBILITY			
1. Based on this assessment, the consumer appears to be medically eligible for NF level of care. Complete regardless of consumer choice. 0 - No 1 - Yes			

SECTION V. AWAITING PLACEMENT			
1. a. FOR:	0. NA	1. NF	2. MaineCare HCB - Elderly, AD
b. AT:	0. NA	3. Home	
	1. NF	4. Out-of-state	
	2. Hospital (specify) _____		
c. Valid eligibility:	from _____ to _____ 0 - NA		
SECTION W. NF/HOSP/HHA DATES			
1. Acute care denial date:	0 - NA		
2. First Non-SNF Date:	0 - NA		
3. Last day private pay:	0 - NA		
4. Late notification date	0 - No	1 - Yes	
5. Bed hold expired	0 - No	1 - Yes	
6. Home Health end date:	0 - NA		
SECTION X. NF FACILITY			
1. a. Will be entering a NF	0 - No	1 - Yes	
b. Is currently in a NF	0 - No	1 - Yes	
c. NF Name:	0 - NA		
d. Eligibility start date:	0 - NA		
e. Reassess date:	0 - NA		
f. End date:	0 - NA		
(30-day MaineCare only)			
g. Admission date:	0 - NA		
SECTION Y. LATE SUBMISSION			
1a. Reason:	1b. To:		0 - NA
<input type="checkbox"/> a. Provider not chosen	<input type="checkbox"/> a. BMS	<input type="checkbox"/> c. BEAS	
<input type="checkbox"/> b. Financial pending	<input type="checkbox"/> b. HCCA	<input type="checkbox"/> d. Other	
<input type="checkbox"/> c. Consumer request			

SECTION Z. COMMUNITY BENEFITS					
FUNDING SOURCE (from Care Plan)	PROVIDER	ELIGIBILITY START DATE	REASSESS DATE	WAIT LIST	
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
RESIDENTIAL CARE REFERRAL					
					<input type="checkbox"/>
BENEFITS DENIED					
FUNDING SOURCE	ACTION	REASON	10-DAY	DISCHARGE DATE	DISCHARGE TO
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		
SIGNATURE					
Assessment Date _____ Assessment Version _____ Assessor Signature _____ Signature Date _____					
FOR OFFICE USE ONLY BEAS/BFI					
<input type="checkbox"/> APRC BEAS request date _____ to _____					
BFI approved begin date _____ to _____					